VERMONT

RAPTIVA® (efalizumab) - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

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PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Sex	Medicaid ID #
	M ☐ F ☐	

Allergies: ☐ NKA or _____

Street Address	City

State	County	Zip Code

Home Phone	Cell Phone

Parent/Guardian	Day Telephone	Night Telephone

Emergency Contact	Relationship	Telephone

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PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number

Telephone Number	Fax Number	Hospital/Clinic Name

Street Address	City

State	County	Zip Code

Contact Person at Office	Prescriber Specialty

iCore Pharmacy Services

MedMetrics HealthPartners

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

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Office of Vermont Health Access
RAPTIVA® (efalizumab)
PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

☐ Plaque Psoriasis

If requesting prescriber is not a Dermatologist, has one been consulted on this case?

☐ **Yes** ☐ **No**

Specialist name: _____ Specialist Type: _____

List previous medications/therapies tried and failed for this condition: (include oral, injectable, topical, phototherapy etc.)

Therapy (and dates)	Reason for discontinuation

Prescriber Additional Comments:

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PRESCRIPTION

Dosage Form and Quantity:

☐ Raptiva 125 mg single use vial

Patient Weight: _____ (kg)

Dispense Quantity:

☐ 4 vials ☐ 8 vials

Sig: Dose/Route/Frequency:_____

Refill X:_____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

Prescriber's Signature: _____ **Date:** _____

Last Updated 01/2009